



## Moving to Accountable Care in East Sussex

### 1. Objective:

This paper considers the question “if we were to implement an Accountable Care Model in East Sussex by April 2017, what do we need to decide and when” through a desk top review of some of the existing models and related emerging research. The Project Brief (scoping) paper is attached at **Annex A**.

### 2. Introduction:

The rapid rise in demand for health and social care is a story for many healthcare systems across the world. Populations are growing and people are living longer. There is an increase in chronic conditions, with more and more of us requiring long-term support. As patients, we also each expect to receive high quality and consistent care, resulting in the best possible outcomes for ourselves and for others.

In East Sussex we are at the forefront of experiencing this pattern of demand and pressure on diminishing resources with a potential funding gap of £200 million by 2018 if status quo is maintained. In response we launched East Sussex Better Together (ESBT) in August 2014 - our bold and transformative approach to developing a fully integrated and sustainable health and social care economy in East Sussex. We aim to achieve this through a 150 week whole system programme designed to invest to the best effect the combined £935 million<sup>1</sup> we spend on health and social care services on behalf of our population.

We are now in week 60 of our 150 week programme with progress made in the first year on key areas of service and pathway redesign to support integrated delivery, such as integrated local health and social care teams, streamlined points of access and urgent care. The programme also aligns key workstreams such as workforce, financial planning, Information Management and Technology (IM&T) and data sharing to enable the necessary changes to back office systems to be made to support the overall transformation to person centred integrated care. The rationale behind ESBT – which is fully recognised and supported by all our inspectors and regulators as critical to sustainability in East Sussex in the long-term - is documented in previous reports and more detail can be found at <https://news.eastsussex.gov.uk/east-sussex-better-together>.

The next year of our programme therefore needs to focus on delivery. To ensure that resources are directed where they are of best use and to guarantee sustainability we will need to be ready to implement new approaches to arranging and delivering local health and social care services by April 2017. This paper is intended to frame the key discussions and decisions needed around the provider landscape - and the necessary next steps we will need to take by April 2017 to achieve our overall aim of sustainability, as we look to secure the future of our NHS and social care for the next generation in East Sussex.

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<sup>1</sup> Indicative 2014/15 baseline figure

### 3. Purpose of this paper:

Faced with these challenges, health and social care systems in the UK and in other countries are being encouraged to test new and different models of care as a response to the changing health and social care needs of the population. The new provider led models of care, such as those proposed in national policies like the Five Year Forward View (FYFV)/Vanguard Programme, provide a menu of options to help design and configure new services. They give CCGs and Local Authorities greater flexibility and control over how to meet local population health and social care needs and offer new ways of delivering more fully realised integration of acute, community, social and primary care.

In summary although the landscape of change isn't yet fully described at the national policy and guidance level, the overall message nationally is one that asks local leaders to be bold and creative in considering potential solutions and to push the boundaries of what is possible. It acknowledges the way the current system works against integration and patient centred outcomes and puts forward alternatives. This includes potentially changing the way health and social care is arranged and paid for using current and emerging commissioning levers available, moving away from a system that focuses on payment for activity at an organisational or episode level to one which provides a payment for patient outcomes at a population level. Capitated outcomes based commissioning, or capitated budgets, are seen by many policy makers as the solution to sustainable services for future generations and local development of the use of capitated budgets at a scale previously not seen in the UK is being actively encouraged.

This paper provides insight about some of the emerging best practice models and early adopters of **accountable care models**, in order to inform considerations about the future model of care which might be adopted in East Sussex.

### 4. Definition of accountable care model:

For this project, we adopt a “global definition” of accountable care: A system in which a group of providers [or a provider] are held jointly accountable for achieving a set of outcomes for a prospectively defined population over a period of time and for an agreed cost<sup>2</sup> under a contractual arrangement with a commissioner:<sup>3</sup>

### 5. Why an accountable care model?

Accountable care models, whereby there is a ‘whole person’ focus that crosses traditional healthcare silos, have emerged internationally as the most likely solution to address the Triple Aims<sup>4</sup> of healthcare systems; improving the health outcomes of populations, enhancing the quality and experience of patient care and reducing the per-capita cost of care. In summary this is usually achieved through using a capitated budget payment arrangement as an enabler to support:

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<sup>2</sup> [Accountable Care: Focusing Accountability on the Outcomes That Matter - WISH \(2013\)](#)

<sup>3</sup> This definition focuses on **population based care**, in line with the best practice models we have reviewed, as opposed to models of accountability based on **episodes or bundles of care**. The latter can also assist with integration - and is sometimes seen as a stepping stone to full accountable care models.

<sup>4</sup> [The Triple Aim: Care, health and cost - Health Affairs Journal \(2008\)](#)

- Reducing fragmentation in the system or care pathway by incentivising collaboration between providers to coordinate care, in order to deliver patient-centred outcomes and eliminating unnecessary treatment or duplication.
- Incentivising community-based prevention (sometimes called the lowest effective level of care) and population wellness, therefore achieving better outcomes for patients as well as greater cost efficiency.
- Potentially removing some, or all, of the commissioner/provider split, and reducing the overall commissioning and contract management functions that are needed.

The models are also considered to give people a stronger voice in their own care and determining what matters<sup>5</sup> through the process of setting of outcomes that matter to the population.

## 6. Types of model:

The NHS Five Year Forward View (FYFV) sets out new models of care which draw on international examples of accountable care provision. Primary and Acute Care Systems (PACS) and Multispecialty Community Providers (MCPs) provide a starting point of two models the FYFV uses to describe the parameters within which local health and social care systems can implement change. Local Vanguard sites focus on the implementation of variations of these two models so that wider learning can be shared and embedded where relevant. The models should be seen as useful opposites and are not intended to be prescriptively applied but used more as guides against which we can develop our own locally appropriate solutions.

MCPs involve “the development of federations, networks and super partnerships to enable general practices to operate on the scale required to deliver a wider range of services”.<sup>6</sup> Adoption of this model would blur the traditional purchaser-provider split and enable GPs to work in partnership [employing or contracting<sup>7</sup>] with others, including hospital specialists, nurses, therapists, pharmacists, social workers and a range of other health and social care professionals in order to deliver more (and more integrated) care in the community.

PACS involve single organisations providing NHS list-based GP and hospital services, together with mental health and community care services.<sup>8</sup> Essentially they will develop vertically integrated care by allowing hospitals to deliver primary care and community services<sup>9</sup>. These might be formed in several ways, including hospitals opening GP surgeries with registered lists and MCPs, as described above, taking over the running of hospitals.<sup>10</sup>

For the purpose of this project we have considered several specific case study examples of accountable care provision which have been cited as good practice. In each of the examples we have highlighted the steps taken to implement the model and

<sup>5</sup> [Accountable Care: Focusing Accountability on the Outcomes That Matter - WISH \(2013\)](#)

<sup>6</sup> [Implementing the NHS Five Year Forward View: Aligning policies with the plan – The Kings Fund \(2015\)](#)

<sup>7</sup> [Reconsidering Accountability in an age of integrated care - Nuffield Trust Viewpoint \(2015\)](#)

<sup>8</sup> [NHS Five Year Forward View – NHS England \(2014\)](#)

<sup>9</sup> [Reconsidering Accountability in an age of integrated care - Nuffield Trust Viewpoint \(2015\)](#)

<sup>10</sup> [Implementing the NHS Five Year Forward View: Aligning policies with the plan – The Kings Fund \(2015\)](#)

key enablers in order to provide insight as to how a similar system could be embedded in our own Health Economy. These are provided in the annexes and cover:

- **The Alzira model (Annex B):** An example of commissioning care for a whole population, defined by a geographical area in Valencia, Spain.
- **Devo-Manc (Annex C):** An example of devolution of responsibilities and resources from central Government, with partners across Greater Manchester developing a combined pooled health and social care budget to establish a “devolved city region focused on people’s health”<sup>11</sup> from 2016. This is an example of a place-based approach to health and social care planning and commissioning within a wider programme of regional ‘total place’ planning and budgeting.
- **Accountable Care Organisations and Virginia Mason (Annex D):** An example of an integrated health service consisting of a multi-speciality group practice (employing 450 primary care and specialist doctors), a network of regional medical centres, training and research institutes and an acute hospital.
- **Canterbury District Health Board (Annex E):** A developing example of an integrated health and social care model from New Zealand.

We have additionally considered some other examples of best practice and early adopters in England to help inform the timeline of steps, including the Integrated Care Pilot in North West London and the Mid-Nottinghamshire Better Together Vanguard. In Mid-Notts an ‘Aspirant Accountable Care Provider Alliance’ of seven independent provider are working with their CCGs to achieve full whole system integration of hospital, community, social and primary care within a single outcomes-based capitation contract<sup>12</sup>, and in the NWL case capitated budgets are being developed for patients with either diabetes or aged over 75<sup>13</sup>.

## 7. The evidence base and Social Care:

It should be noted that many of the international models are not strong on detail about social care, with much of the debate about accountable care to date existing within the health arena. However, the value of social and behavioural interventions delivered in community-settings to provide the lowest effective level of care and meet outcomes is not contested either. In the UK the Vanguard sites and early implementers of outcomes based capitated budget models are clear on the role of social care and that consideration of the scope of social care services to be included in the capitated budgets is of fundamental importance, with the accompanying need to review social care services, budgets and contracts for use within a single capitated budget. This extends beyond the free elements of social care to elements which can be charged for.

Various UK national policy commentaries outline the option of CCGs integrating in a different way with Councils to lead to fuller integration with social care at the commissioning and delivery level. Devo-Manc is an example of how this could be done using a locally accountable place-based joint planning process to manage a much

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<sup>11</sup> [Letting Go: How English Devolution can help solve the NHS care and cash crisis - Reform \(March 2015\)](#)

<sup>12</sup> <http://www.bettertogethernottingham.org.uk/about-the-programme/obc/>

<sup>13</sup> <http://integration.healthiernorthwestlondon.nhs.uk/>

larger delegated and pooled health and social care budget. Major projects are planned this year in Greater Manchester to test implementation at scale. The tests will help quantify impacts to inform the development of a local 'health and social care strategic sustainability plan' as a key next step to the design of full integration. This includes seven day access to primary care and reconfiguration of hospital-based emergency medicine. At the current time it is not clear what level of organisational or structural change might be recommended in the delivery model, and whether this would be any different to the accountable care models suggested in the FYFV (for example the possibilities may include social enterprise or 'arm's length' arrangements).

Equally the third sector and housing are seen in many of the UK examples as a critical to the delivery of health, social and behavioural care. Much of this is commissioned via local authority social care departments and attention should also be paid to whether some or all of these services, budgets and contracts are in scope for an accountable care model managed through an outcomes based single capitated contract and payment.

Ultimately the new accountable models of care require an identified provider or providers to lead on the integration and take responsibility for managing a capitated budget to deliver the specified outcomes. It may be that lead clinical care providers could be asked to demonstrate a strong capability to integrate with social care and the third/housing sector as part of winning outcomes-based capitated contracts (as in the Mid-Notts example mentioned above). This could include providing evidence of plans to coordinate delivery level relationships and tactically commission the services needed to deliver accountable care outcomes. Alternatively in some areas Councils are seen to be the natural democratic leader, and this can be a benefit in managing local sensitivities when introducing new accountable care models locally, perhaps especially where deeper levels of place-based devolution are proposed.

## **8. Key common characteristics and enablers of Accountable Care models:**

As the annexed examples demonstrate, there are distinct differences between models of accountable care provision, even within this small selection of examples. However there are also some key common characteristics that apply across several of the best practice examples, summarised below. These would therefore need to be considered in East Sussex if we were to implement an accountable care model by 2017.

### **(i) Payments and incentives**

- Contracting for quality and paying for outcomes
- Capitated payments and length of contract
- Managing financial risk

When assessing characteristics and capabilities for shifting to accountable care, PwC summarise that "this shift is largely characterised by larger, longer term contracts with a shared set of outcomes and performance measures".<sup>14</sup> The way commissioners decide to pay for health and social care can support different providers to deliver services in an integrated way and potentially enable a more sustainable provider landscape:

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<sup>14</sup> [Shifting to accountable care: Characteristics and Capabilities – PwC \(2014/15\)](#)

- Linking payment mechanisms to the achievement of set quality metrics and specified outcomes is already widely recognised as an important aspect for better and more integrated care and is a feature of accountable care models.
- The most identified mechanism for payment in accountable care models is capitated payment contracts, which are often longer contracts (as seen in the Alzira model). Capitated payment is also cited by The Kings Fund as a viable way to commission MCPs.<sup>15</sup>
- Capitated payments are an arrangement where a provider (or group of providers) is paid to deliver care to a target population across all of the different care settings that they might need. This can be populations with similar care needs (for example patients with long term conditions, frail and elderly patients, or children with disabilities) or for whole populations in a geographical area (usually where system maturity for capitated payment has been developed).
- In this system payments are calculated on a lump sum basis per patient and if the care costs less than expected, there will be a financial gain to the local health system.
- This is expected to make it more likely to shift the focus to continued wellness (as a defined population would generally have both well and unwell people within it) and early intervention (which is widely recognised as having a positive impact on cost as well as patient outcomes) and to get the right treatment to patients in the right settings at the lowest level of effective care. In mature models any gains through more efficiency and productivity are shared between providers and commissioners.
- In capitation payments risk is shared with commissioners as well as the gains derived from more efficiency and productivity. In order to manage issues of provider and commissioner capability and trust in this area Monitor recommend that local care economies introduce a capitated payment approach initially for a specific target or sub-segment of the population (such as patients with multiple long term conditions), and a cautious approach to implementation for the whole population:

Capitation for a target population provides an opportunity for organisations to build the capabilities of the integrated care model, develop patient-level linked datasets, fix financial incentives and adjust (risk and gains) sharing factors each year so that providers can take on more financial risk before this approach is rolled out to a larger population. The approach outlined in this document can also be used to support implementation of capitated payment for the whole population but further consideration will need to be given in determining the minimum population size and the management of financial risk.<sup>16</sup>

As a key characteristic of an accountable care model, **Annex F** outlines further information about capitated payments, and the decisions/steps for commissioners and providers in East Sussex if we were to implement a capitated payment within an accountable care model by 2017.

Most of the literature makes a direct link between managing financial risk and the size and nature of the capitation population i.e. avoiding making the group too small to allow

<sup>15</sup> [Commissioning and Contracting for integrated care - The Kings Fund \(2014\)](#) and [Commissioning and funding general practice: Making the Case for family care networks – The Kings Fund \(2014\)](#)

<sup>16</sup> Capitation: a potential new payment model to enable integrated care – Monitor (2014)

variations in care cost to be averaged out and excluding from the payment arrangements infrequent, high cost services or patients whilst maintaining the patient care delivery model. The length of the contract term is also seen to be a significant lever in encouraging the investment by the provider in prevention and improving productivity in the long run to yield the expected health economy benefits – contracts of less than 3-5 years are seen to be too short to make investments worthwhile to providers.

With most of the examples it is too soon to say that accountable care has delivered the overall improvements expected; and they don't give an outline what would happen if outcomes aren't improved during the course of the contract. The management of this overall risk is something that commissioners and providers in East Sussex will need to consider. There is an assumption in the literature about making allowance for capability to be developed over time. The relationship with informatics functionality to monitor outcomes and improvements and make adjustments as part of ongoing contract management is of fundamental importance here (see paragraph 8ii below).

## **(ii) Interoperable IT, data and informatics**

An analysis of the case studies included and other examples of best practice refer to the need for highly developed and integrated IT networks, enabling real time information access through shared electronic health and social care records, for example between primary and secondary and social care providers and integrated data sharing between emergency and out of hours GP services. This ensures that care is centred on the patient in all care settings, avoiding unnecessary delays and duplication. Information and the appropriate information systems will be crucial in supporting changes in behaviour of patients, providers and commissioners by informing and supporting decision-making, delivery of care and enabling better outcomes for the service user.

There are three broad informatics functions:

- Better care through empowering service users through care (and self-care) planning and managing personal budgets.
- Better care delivery and supported professionals through information sharing with and between care settings to inform efficient and effective professional decision-making and the right tools to improve efficiency and productivity.
- Better outcomes through expert analytics and tools for commissioners and providers to plan, implement and manage integrated care, including data warehousing and dashboards capability.

Access to reliable, rich and informative data is important for:

- Correctly setting up of payment mechanisms - for example in establishing population cohorts and a weighted capitated system.
- Robust performance management - the need to be able to robustly measure performance, quality of care, outcomes and efficiencies.
- Providers - as the accountable carer, to understand how to improve outcomes for their patients and where to aim interventions and;
- Measuring effectiveness of activity and interventions on outcomes and quality, with a feedback loop to inform future decisions.

ESBT workstreams for IMT, finance and performance are fundamental to successful system transformation and the delivery of person centred outcomes based budgeting and would need to be aligned fully to a move to accountable care managed through a capitated payment.

### **(iii) Leadership and the Governance around decision making**

There is an emphasis in the new models of care in the NHS for diverse solutions and local leadership, in place of further structural distraction at the national level.<sup>17</sup> The implementation of an accountable care model is likely to require:

- System leadership - new kinds of leadership are needed to make a reality of new models of care. Specifically there is a likely shift within accountable care models from organisational leaders to whole system leaders.<sup>18</sup>
- Provider leadership - clinical and managerial leadership to develop a culture of collaboration, to come together in alliances/ networks to deliver care effectively across organisational boundaries.
- Structures enabling effective delivery and shared decision making.<sup>19</sup>

### **(iv) Culture and people**

The building of a culture of accountability and collaboration within and across health and social care organisations - including investment in staff training and engagements - is a key feature in the example models. It is also cited as a key enabler in other best practice examples, such as the Jonkoping Model in Sweden.<sup>20</sup> This includes the need to develop a clear strategy and compelling vision for delivering outcomes that matter to people across organisations<sup>21</sup> with the implied knock-on effect of a positive impact on workforce recruitment and retention.

This is also relevant within the models; for example in addressing the complexities in bringing together the cultures of primary and secondary care. For example:

- In PACS “the prominence of acute hospitals in the NHS means that GPs and staff running community services are sometimes fearful that they will be the poor relations in integrated care models”.<sup>22</sup> Therefore in a PACS model the need to focus on involving GPs and understanding and addressing any concerns they may have will be crucial. As the new models of care can be operationalised through networks supported by agreements and sub-contracting relationships there is no requirement placed on professionals to change their employment arrangements (for example all being employed in one organisation) or expectations placed on GPs to give up Independent Contractor status (unless they want to). The primary issue to be assessed is the capability of the accountable care provider (who takes the role of

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<sup>17</sup> [NHS Five Year Forward View – NHS England \(2014\)](#)

<sup>18</sup> [Implementing the NHS Five Year Forward View: Aligning policies with the plan – The Kings Fund \(2015\)](#)

<sup>19</sup> [Shifting to accountable care: Characteristics and Capabilities – PwC \(2014/15\)](#)

<sup>20</sup> In Sweden the training of staff through the Qulturum training system and the Esther Project (which considers a fictional 88 year old woman with several chronic conditions in service design) focus the culture on the refusal to accept the status quo, underlined by the mantra of all in the system having two jobs to do; our job and to improve our job - [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>21</sup> [Shifting to accountable care: Characteristics and Capabilities – PwC \(2014/15\)](#)

<sup>22</sup> [Implementing the NHS Five Year Forward View: Aligning policies with the plan – The Kings Fund \(2015\)](#)



the care 'integrator') to engage and work with other organisations beyond its boundaries to ensure the lowest level of effective care.

- Other characteristics of organisations shifting to accountable care are that “they are able to identify, recruit, and retain appropriately skilled workforce” and have an “on-going commitment to workforce development and an emphasis on joint working”<sup>23</sup> This may include the need for demonstrable capability (or training) in managing contractual negotiations, contracts and delivering outcomes. In MCPs, for example, there will need to be interested and capable general practitioners operating at sufficient scale to take control of a capitated budget and deliver out of hospital care services which is acknowledged as “a radical shift from the current model of general practice to the use of federations and networks of practices able to work at the scale needed to ensure effective integration of services.”<sup>24</sup>

It is too soon to say whether the new models of care will have a positive impact on the ongoing workforce planning recruitment and retention issues in East Sussex, which are reflected in the current discussions between NHS Employers and the British Medical Association (BMA) which highlight the level of discord surrounding consultant and junior doctors' pay, conditions and working arrangements, and the ongoing difficulties in attracting qualified nursing and social care staff to the county. However, there is some anecdotal evidence of higher levels of satisfaction for physicians in having both responsibility and control of the entire pathway of their patients' care as part of a new business model. How these issues might be tackled in East Sussex as part of a move to an accountable care model will need to be considered – including the quality and type of work offered by the model, opportunities for development and attractiveness of the working arrangements as well as levels of organisational ownership offered to staff and the potential for gains-sharing in the future.

#### **(v) Patient choice**

There are examples within those presented of the importance of patient choice being built into the design of the model. In the Alzira system (**Annex B**) part of the payment mechanism is that patients have the choice to go elsewhere with the provider paying 100% of the cost of the care if they chose to do so.<sup>25</sup> This is therefore a further incentive to drive up quality and service, in order to encourage patient loyalty. This is also an important aspect of ACOs in the USA, particularly following the managed care backlash<sup>26</sup> in the 1990's Health Maintenance Organisations (**Annex D&F**), whereby the lack of emphasis on quality and outcomes and patient choice led many to think that the least complex patients were being 'cherry picked' with primary care physicians were seen as 'gatekeepers' preventing access to services.

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<sup>23</sup> [Shifting to accountable care: Characteristics and Capabilities – PwC \(2014/15\)](#)

<sup>24</sup> [Commissioning and funding general practice: Making the Case for family care networks – The Kings Fund \(2014\)](#)

<sup>25</sup> [The Search for lower cost integrated healthcare: The Alzira Model – from the Valencia Region in Spain – NHS Confederation \(2011\)](#)

<sup>26</sup> The fore-runner to the ACO model in the US; managed care describes a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care usually delivered through Health Maintenance organisations in the 1990s

## 9. Potential challenges that will need to be addressed:

In addition to ensuring the key enablers are in place for accountable care, there are several levers identified in some of the broader literature that will help us make the shift to an accountable care model in East Sussex by 2017:

- **Initial cost set up without access to the Vanguard fund:** As the case for transformation underpinning ESBT highlights, we cannot afford the status quo. However, the cost for setting up/ testing a new model and the time it may take to realise savings present a challenge that we will need to work with. The WISH report on accountable care highlights “the emerging evidence strongly indicates that accountable care can encourage innovation and improve the quality of care. There is also some early evidence for cost savings, but it is less strong, particularly during the initial years when investments are needed to change systems and build capabilities”.<sup>27</sup> The Nuffield Trust concluded that cost savings tend to be indiscernible in the first few years.<sup>28</sup> However, the evidence is variable, particularly as many accountable care models are in very early stages of being established. Examples of significant savings have been identified particularly in more embedded systems, indicating the long term benefits of the models. Hence the encouragement in most models to put in place longer contracts to incentivise provider investment in the changes needed to support a move to the lowest effective level of care.
- **Procurement and tendering processes:** The Kings Fund notes that “there remains uncertainty among both commissioners and providers on how competition rules operate in practice and a concern that they create further challenges to the development of new care models”. The Kings Fund suggest that local commissioners should be encouraged to create their own solutions to overcome such challenges when implementing new initiatives<sup>29</sup> and local legal and procurement input into the design of the process we use will be essential. National guidance and legal advice is emerging on this issue and new contracting arrangements for prime contractors will need to be tested in line with this. Some more developed examples of how other areas are tackling this are now coming through the from the Vanguard sites including Capability Assessment of an alliance of local providers, with a possibility of a default to open tendering (Mid-Notts), and Special Purpose Vehicle development by Northumbria NHSFT and Northumberland CCG to create a vehicle for an Accountable Care Organisation and manage the associated risks for the provider.<sup>30</sup> The legality question is also pertinent to the Devo-Manc example, as this involves devolved powers from Whitehall which East Sussex does not have the opportunity to access at this time.
- **Regulatory and Inspection regime support:** We will need to work closely with our multiple regulatory and inspection regimes, including Monitor, the CQC and NHS

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<sup>27</sup> [Accountable Care: Focusing Accountability on the Outcomes That Matter - WISH \(2013\)](#) describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care

<sup>28</sup> [Evaluating integrated and Community Based Care – Nuffield Trust \(2013\)](#)

<sup>29</sup> [Implementing the NHS Five Year Forward View: Aligning policies with the plan – The Kings Fund \(2015\)](#)

<sup>30</sup> <http://www.northumberlandccg.nhs.uk/wp-content/uploads/2013/07/20150415-Item-8-Primary-and-Acute-Care-System.pdf>

England to ensure their full permission and support at the earliest stages for the case for change that underpins a move to accountable care in East Sussex and the transformation we'll need to do further down the line to get there.

### 10. Applying the models by April 2017: what would we need to decide and when if we were to move to an accountable care model?

This timeline applies some of the aspects of UK Vanguard sites and early integrated care implementers, in particular Mid-Nottinghamshire 'Better Together Re-commissioning Process' and North West London 'Wholes System Integrated Care'. It is cautious and assumes a level of procurement and therefore lead-in time is needed in contracting for a new accountable care model, and has been designed to fit with an implementation timetable of April 2017. The procurement process can also be seen as a way of actively encouraging new provider networks to form to make up the Accountable Care Organisation model.

It is recommended/ recognised that further work is needed as a priority to define a local process that can help achieve local objectives at speed and fits with procurement and the NHS procurement rules and contracting arrangements. It may be that on further exploration formal full procurement processes can be avoided if this is seen to be beneficial, hence procurement milestones have been noted as potential milestones in the following high level timeline:

	<b>Milestone and decision</b>	<b>Timeline</b>
<b>1</b>	<b>Decide on overall preferred model:</b> <ul style="list-style-type: none"> <li>• Multi-Specialty Community Provider</li> <li>• Primary and Acute Care System</li> <li>• Adapted local model e.g. alliance of providers to come together with an identified single contract-holding organisation responsible for leading achieving service integration</li> <li>• All of the above supported by a capitated budget</li> </ul>	<b>April 2016</b>
<b>2</b>	<b>Initial conversations with Primary Care Providers, Acute and Community Provider Trusts, Mental Health and Ambulance Trusts:</b> <ul style="list-style-type: none"> <li>• Signal intention to design an outcome based accountable care model and parameters of consideration e.g. level of organisational and structural change envisaged, move to capitation for specific populations to support integrated care, incentivise prevention and shift of activity and resource to community settings.</li> </ul>	<b>April 2016</b>
<b>3</b>	<b>Initiation with key providers:</b> <ul style="list-style-type: none"> <li>• Identify key provider partners and broker initial discussions with prospective partners who will act as 'coordinators' in the new delivery model</li> <li>• Design the procurement process to re-commission outcomes based capitated contract covering capability and scope of services</li> </ul>	<b>April 2016</b>
<b>4</b>	<b>System-wide decision on vision and case for change to a new accountable model of care</b> <ul style="list-style-type: none"> <li>• Includes governance structure, to include representation of</li> </ul>	<b>April 2016</b>

	<p>health and social care coordinating partners and commissioners to lead overall service reform and ultimately monitor performance, manage financial risk and consistent adherence to care delivery. Needs to include a decision-making board component for providers with service level agreements between them.</p> <ul style="list-style-type: none"> <li>• Communications and Engagement Plan signed off covering staff, patients, clients, the public and carers.</li> </ul>	
<b>5</b>	<p><b>Design and agree future commissioning and contracting model:</b></p> <ul style="list-style-type: none"> <li>• Contract length (e.g. five to ten years)?</li> <li>• A key challenge is to integrate contract arrangements across all providers, particularly across primary and secondary care so that all or most of the services to be covered by the capitated model can be commissioned from a single prime provider (e.g. via a Special Purpose Vehicle or an Alternative Provider Medical Services (APMS) compliant NHS Standard Contract). Currently different contract forms are prescribed for primary and secondary care. Two options are currently being developed by NHS England: <ul style="list-style-type: none"> <li>○ Optional supplement to the NHS Standard Contract, rendering it compliant with APMS Directions and suitable for use as a prime/ACO contract for a package of primary and secondary care paid for on a capitation basis</li> <li>○ Umbrella Agreement to be entered into by all providers and commissioners involved in a pathway of care for a defined population. This can tie together parallel primary and secondary care commissioning contracts to form an ‘alliance’ or quasi-prime contractor/ACO arrangement, either of which may be the basis for a capitation-based model</li> </ul> </li> </ul>	<b>April 2016</b>
<b>6</b>	<p><b>Full Business case, covering detail about key design elements:</b></p> <ul style="list-style-type: none"> <li>• Identifying the patient cohort (also see <b>Annex F</b>). <ul style="list-style-type: none"> <li>○ Whole population in a given area?</li> <li>○ Specific sub segments of the population?</li> </ul> </li> </ul> <p>(N.B it is likely to be more appropriate and practical (at least in the short to medium term to focus on specific patient cohorts with similar needs.<sup>31</sup> Grouping might be by type of condition and age, social and demographic factors, utilisation risk - risk stratification - and behaviour. For example this might be the elderly frail and those with multiple long-term conditions where the grouping is relevant to both health and social care).</p> <ul style="list-style-type: none"> <li>• Defining the services to be covered by capitation covering all (or most) of the care needs of the selected patient cohort: <ul style="list-style-type: none"> <li>○ Primary, acute, community, mental health, acute and social care (this could be the elements of social care that are free e.g. assessment and reablement, and/or elements of</li> </ul> </li> </ul>	<b>July 2016</b>

<sup>31</sup> [Capitation: a potential new payment model to enable integrated Care - NHS England and Monitor – \(November 2014\)](#)

	<p>charged for care such as residential, nursing care and home care and/or third sector social care)</p> <ul style="list-style-type: none"> <li>○ Identify exclusions based on low frequency and very high cost to facilitate risk management.</li> <li>● Identify key service budgets to set up the pooled capitated budget</li> <li>● Establish methodology to link and collect patient level data for all care settings to help commissioners and providers identify resource and cost flows in the local health and social care system</li> <li>● Selecting a method for determining the price <ul style="list-style-type: none"> <li>○ Price per capita based on estimated average commissioner spend per patient</li> <li>○ Use tools e.g. Monitor Care Spend Estimate Tool, LTC Year of Care Commissioning Stimulation Model, tailored and sense-checked using local data</li> <li>○ Reflect likely margin of error of estimates in the agreed price for capitated payment</li> </ul> </li> <li>● Planning financial risk mitigation mechanisms <ul style="list-style-type: none"> <li>○ Either one or other or a combination of prospective and retrospective risk mitigation</li> </ul> </li> <li>● Designing provider-to-provider payments <ul style="list-style-type: none"> <li>○ Volume of activity to be undertaken by sub-contractors, activity reporting and monitoring process</li> <li>○ Where activity data is of insufficient quality to serve as a basis for payments use block payments with an accompanying payment for performance (will also be important to enable to enable small third sector providers to manage cash flow)</li> </ul> </li> <li>● Defining financial gain/loss sharing arrangements <ul style="list-style-type: none"> <li>○ E.g. use of 'stop-loss' to set maximum losses for the capitated budget holder. The cap is extended over time, as the capitated budget holder builds up financial risk management capacity</li> </ul> </li> <li>● Defining quality and outcomes incentives <ul style="list-style-type: none"> <li>○ Performance on quality and outcomes could be included in the payment approach</li> <li>○ Clinical quality of care, patient experience (including waiting times) and patient involvement in decision-making (including choice)</li> <li>○ Possible adaptation of CQINS targets across providers</li> </ul> </li> </ul>	
7	<p><b>Potential Milestone: Initiate capability assessment process with identified 'coordinating providers' designed to:</b></p> <ul style="list-style-type: none"> <li>● Evaluate the ability of these organisations to work together on local challenges <ul style="list-style-type: none"> <li>○ Governance arrangements of coordinating partners</li> <li>○ Delivering system benefits</li> </ul> </li> <li>● Propose a programme of integrated service transformation (with links to workforce, IT, estates and patient engagement)</li> <li>● Move to open market procurement at any point between</li> </ul>	<p><b>July - October 2016 NB depending on the outcome of milestone 5</b></p>

	February and December 2016 if coordinating partners fail capability assessment gateways	
<b>8</b>	<b>Shadow test and refine capitated budget:</b> <ul style="list-style-type: none"> <li>• Develop information and capability requirements, such as the ability to link patient-level data across all types of care and collect robust patient-level costs of care provision</li> <li>• Monitor and evaluate to inform gains and risk sharing approach</li> </ul>	<b>October 2016 – March 2017</b>
<b>9</b>	<b>Potential milestone: Pending outcomes of capability assessments move to contract set up:</b> <ul style="list-style-type: none"> <li>• Finalise legal and pooled budget arrangements for the capitated budget: <ul style="list-style-type: none"> <li>○ Lead commissioner?</li> <li>○ Joint Commissioning Board/other governance structure?</li> </ul> </li> </ul>	<b>January - March 2017 NB depending on the outcome of milestone 5</b>
<b>10</b>	<b>Move to full outcomes based accountable care model:</b> <ul style="list-style-type: none"> <li>• Commence outcomes based capitated contract with a single contractual party who will be the Accountable Provider Organisation on behalf of a network or alliance of providers</li> <li>• Services are fully integrated with home and community the default care setting to achieve the lowest level of effective care</li> </ul>	<b>April 2017</b>

## 11. Conclusion

The national and international picture of rising and changing demand for health and social care is reflected locally in East Sussex. Staying as we are is not an option in the context of ever increasing demand, a need for high standards of care and a potential funding gap of £200 million by 2018 if the status quo is maintained. It is also widely acknowledged that the way the health and social care system is currently arranged actively mitigates against true integration and accountability for patient and population outcomes. National policy developments and local experience point to a compelling case for change in the current supply-led health and social care system to more sustainable demand-driven health and social care. This is characterised by whole person accountable care in a community based system that can positively incentivise the lowest effective level of care and the highest possible quality of care.

Accountable care and increasing flexibility in national policy offers a new and exciting opportunity to address the issues of service sustainability and integration in East Sussex. The size and urgency of the challenge we face is unprecedented, and it is imperative that leaders seize this opportunity to make good decisions that enable whole system reform at scale and pace. The scope for innovation is wide, with the NHS FYFV putting forward new models of care (PACS and MCPs) which serve to describe the parameters of the new flexibilities on offer to local commissioning and provider organisations. We should not be too constrained by these suggestions - there are no fixed ways to apply the new models of care and contracting and how they should be interpreted; local areas are asked and encouraged to use these suggestions as a guide to build on our local strengths to address issues and challenges creatively. Whatever approach is taken in East Sussex it will need to be local to East Sussex, organically evolving to suit the local context and taking learning from elsewhere where needed. A timeframe of April 2017 means that we will need to be 'fleet of foot' in implementation,

being prepared to test new ways of working and manage implementation in parallel in order to make the necessary transformation to the local health and social care system that is needed by 2018.

There is system-wide leadership and collaboration needed for transformation to accountable care and the local provider landscape will inevitably influence decisions. Longer-term outcomes based contracts underpinned by a capitated budget are the significant game-changer for integrated care, quality and efficiency, and progress can start to be made locally by setting out a clear path towards transforming to contracting and payment for outcomes to allow provider markets to start to reorganise, form networks and grow capabilities. Progress is needed urgently for implementation by April 2017 in order to yield the maximum benefit from a transformed health and social care system for our local population, in line with our ESBT 150 week plan of whole system transformation to secure sustainable services for future generations in East Sussex. This provides the rationale and momentum we need to make innovative new accountable care models a reality.

24 September 2015

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## **Annex A**

### **High level options appraisal of provider led models of delivery**

#### **Project Brief**

##### **1. Introduction and project aims**

New Government spending plans and policies set out unprecedented change to the overall financial envelope that public services will operate in over the next three - five years. This will require new approaches to arranging and delivering local health and social care services in the future in order to manage impacts and ensure sustainability in the longer term.

East Sussex Better Together (ESBT) presents an opportunity to deliver a sustainable long-term solution across the four health and social care commissioning organisations and provider organisations, through focussing more clearly on the total £1 billion investment made in health and social care services in East Sussex. New models of care put forward in the NHS Five Year Forward View, as well as other locally generated models, enable CCGs and Local Authorities greater flexibility and control to meet local population needs.

In keeping with the ambition of ESBT for long-term sustainability of the local health and social care economy - the aim of this short project will be to examine the new models of care to enable initial stage decisions to be reached about fit and acceptability in the local East Sussex context.

##### **2. Context**

In the NHS Five Year Forward View, provider led models are seen to be ways of delivering more fully realised integration of acute, community, social care and primary care. In summary this is achieved through:

- Reducing fragmentation in the system or care pathway.
- Incentivising community-based prevention and therefore achieving better outcomes for patients as well as greater cost efficiency.
- A third area of efficiency is thought to be achieved through removing some or all of the commissioner/provider split, and reducing the overall commissioning functions that are needed.

There are various suggested ways available to CCGs and Councils of achieving provider-led models of care including:

- Accountable Care Organisations (ACOs) / Primary and Acute Care Systems (PACS) / Multi-speciality Community Providers (MCP) – all ways of achieving vertical or horizontal integration across acute, community and primary care with elements of social care brought in.
- Locally generated merger models of local NHS provider organisations and Council provision – for example through creating Arms Length Management Organisation (ALMO) or Local Authority Trading Company (LATC) social enterprise-style models to create a separate delivery arm across both health and social care. These can be supported by the newly emerging Devo-Manc model of nationally devolved pooled budget arrangements and an infrastructure of joint planning and commissioning at the local level.

Each approach has different implications for local accountability and control. In East Sussex both of these models would seem to have the best potential fit for East Sussex. This scoping exercise is intended to assist in further determining which model would best support the overall aims of ESBT.



## **Annex A**

### **3. Key tasks**

The project is to establish if we are to implement an ACO by April 2015 what do we need to decide and when. In order to scope the models and considerations for implementation further the following tasks will be undertaken:

- A high level options appraisal exercise to enable a compare and contrast exercise between the two key models:
  - Accountable Care Organisation / PACS – a model such as the Virginia Mason or La Ribera (Alzira/ Valencia) model.
  - Locally generated model – such as DevoManc.

This will include an outline sketch of each model and summary description or list of the core characteristics of each model, e.g. contract model and payment model, workforce etc. (N.B – there is no need to compare and contrast with ‘as is’).

- Scope key stages of development pathway for each model working back from April 2017. This is a milestone date where clear plans and preparation work would need to have been undertaken to be ready for full implementation of any new model in 2017/18. The development pathway will describe:
  - What would need to be done by when.
  - What shifts would need to be managed (financial, political, etc.).
  - What would the governance process look like to make decisions (for both CCGs and the Council).
  - Draw out and understand where time could potentially be saved through the learning from other areas.
  - Include high level analysis of key blocks and barriers, for example contract and payment model issues, procurement pathway considerations.
- Produce timeframe for decision-making, including:
  - Flagging the key issues that will need a decision on adopting the preferred model i.e. a timetable that surfaces and evaluates the critical issues.
  - Local political process decisions.

### **4. Methodology**

Desk top review of models and good practice both UK-wide and internationally to be carried out by Kat Banaghan and Vicky Smith. This will include early information from UK Vanguards and fast followers (if possible) e.g.

- Northumberland CCG and Northumbria NHSFT PACS/ACO Vanguard.
- DevoManc and other arms length/trading examples where relevant.
- International examples from the US, Europe and wider, such as Virginia Mason, Alzira, model etc.

### **5. Outputs / deliverables**

A short scoping paper that captures the following core information for both models:

- Summary list of core characteristics of each model, including the evidence base for the approach where known such as population coverage and elements of service, contracting/payment mechanism etc.
- High level description of how the models were implemented (not whether they should be implemented) .

## **Annex A**

- Criteria for success (using evidence from what others have used) – e.g. provider, population type, cost etc.
- Summary of key shifts, and barriers and therefore decisions necessary to achieve implementation of the model.
- Key stages of the development pathway.
- Decision timetable.

### **6. Timescale**

- High level scoping of development pathway for both models by September 2015 to Keith Hinkley, Amanda Philpott, Wendy Carberry, Paula Gorvett and Martin Hayles.
- Keith Hinkley, Amanda Philpott, Wendy Carberry and Paula Gorvett to determine next steps. E.g. Report to October 2015 ESBT Programme Board.

18 08 15

Vicky Smith, Adult Social Care and Health  
Kat Banaghan, East Sussex CCGs

## Annex B

### The Alzira Model

The Alzira model is widely cited as an example of a successful model of accountable care provision, having seen the delivery of better outcomes at a lower cost.<sup>1</sup>

#### Where:

- The model originated in Valencia, Spain and is named after Alzira, the town where the initiative started.
- The model is sometimes alternatively referred to across research as 'La Ribera' (Hospital de La Ribera was where the mixed management model was first established), 'Ribera Salud' (after the principal contractor Ribera Salud – also known as Ribera Health or RSUTE) or the 'Valencia Model' (after the region from which the model originated).

#### When:

- The original model was established in 1997 and implemented in 1999 when the Valencia Department of Health entered into a public-private partnership arrangement with Ribera Health.
- The contract was terminated in 2003 due to some initial issues (explained below).
- The second contract then started in the same year, with a revised per capita fee set and the extension to cover primary as well as secondary care.

#### Population/ Coverage:

- The Alzira model serves a 'catchment area' of 245,000 inhabitants. Prior to the model being set up locals seeking hospital treatment often had to travel more than 40km to Valencia. To close this gap in its provision of health services, the regional government of Valencia looked at novel approaches to financing hospital services using private capital. It opted to put the contract to build and run a new public hospital out to tender.
- Subsequent contracts mean that 20% of the Valencia region (around 850,000 people) is now covered by similar contracts.<sup>2</sup>

#### Type of Model:

- A Public-Private mixed management accountable care model which has incentivised out of hospital care. This [PwC and Ribera Salud](#) visual summary of the model summarises the set-up.

#### Summary:

Alzira is a mixed management model in the public health system, by which a private company is awarded a contract to build and run a public hospital. The private contractor -Ribera Health - receives a fixed annual sum per local inhabitant to deliver all of the healthcare needs for them. The keys of the model are:

- **Public funding** on per capita payment basis.
- **Public control**, by the Valencian Government through the commissioner working in the Hospital. Ribera Health must comply with clauses to the contract and the government retains power to inspect, regulate and impose sanctions.
- **Public ownership**, which is guaranteed at all times. The health centre has been contracted out but remains a public hospital, public land and belonging to the wider public network of healthcare. Hospital and equipment refund to public ownership.

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<sup>1</sup> This Information in this report is summarised primarily from [The Search for lower cost integrated healthcare: The Alzira Model – from the Valencia Region in Spain – NHS Confederation \(2011\)](#), the [La Ribera website](#) and the [PwC and Ribera Salud visual summary](#) of the model. Other sources are referenced specifically where applicable.

<sup>2</sup> [Case Study on Public-Private partnership in Valencia, Spain – Reform \(2014\)](#)

## Annex B

- **Private Provision**, with the contract for providing the services awarded for a fixed period to a private company to efficiently manage the operation of this public service. For Alzira this included the building of the new Hospital, investment in technology and new infrastructures (e.g. a new primary care centre of Alzira). Risk transfer assumed. Employs own medical staff and applies own management “know how”<sup>3</sup>.

### **Finance and contract:**

- The provider works to a capitation-based budget for the defined population over the long term, providing financial stability.
- The whole system is incentivised to keep people out of hospital and in the least intensive setting. Proactive and preventative care is incentivised in order to avoid admissions, with hospital reserved for the critically ill and with integrated working between primary and secondary care doctors who have aligned incentives.
- Quality outcome indicators for driving up performance are set and staff performance measured against these. Transparency forms part of the system; quality information made public to allow patients/ others to compare and contrast the care provided with other systems.
- The money follows the patient is considered the Alzira mantra to improvement<sup>4</sup> – therefore there is a financial incentive for quality of care to be driven up to encourage loyalty from patients; Ribera Healthcare has to pay 100% of the costs for those patients who chose to be seen by another healthcare system. Patient choice built into the system financially.
- Principle of subsidiarity.
- Contract for a period of 15 years or more. For the commissioner this results in a relatively predictable cost through the annual capitation allocation, which transfers risks of cost.

### **Successes:**

- Generally considered to have high patient satisfaction and to be patient orientated (the money follows the patient).
- Lower capitation costs.
- Lower waiting times for A&E and elective procedures.
- Average length of stay reduced and lower re-admissions to hospital after three days.
- Lower staff absenteeism and higher staff satisfaction reported.
- Model rolled out elsewhere by the Government in Valencia. For local Government the capitation cost is 75% of the cost per person in the rest of the Valencia Region.<sup>5</sup>

### **Enablers:**

- The right financial incentives including rewarding improved health outcomes; including a capitated budget and a long contract to enable longer term investment decisions.<sup>6</sup>
- A strong management and staff culture (with an expectation of uniform compliance with operating procedures, clinical pathways, quality, guidance etc. A strong performance management system and use of staff incentives).
- Highly developed ICT systems in place. These include real time data displays and a fully integrated care record accessible in all locations.
- Innovative use of technology for services; use of networks to provide diagnostic support to avoid duplication.

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<sup>3</sup> [La Ribera website](#)

<sup>4</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>5</sup> [Accountable Care: Focusing Accountability on the Outcomes That Matter - WISH \(2013\)](#)

<sup>6</sup> [Lessons from Alzira: an NHS Provider Perspective - PwC \(2014/15\)](#)

## Annex B

### Issues/ learning to inform implementation of a similar model of accountable care:

- There were financial problems with the original contract<sup>7</sup> which were generally attributed to cost shifting between primary (not included in the original model) and secondary care and an agreed capitated fee much lower than elsewhere.<sup>8</sup>
- The contract was considered unsustainable and terminated in 2003 by the Valencia Department of Health. The second contract then started, with a revised per capita fee set and the extension to cover primary as well as secondary care to avoid the cost shifting issues.
- Therefore clear need to (a) get the financial incentives and payments right and (b) create a system that favours integration (primary, secondary, social and whole system care).
- As with all of these models, they are relatively new and therefore detailed evidence on longevity and long term outcomes is yet to clearly emerge.
- The NHS Confederation report notes that “the model is likely to squeeze out all other providers.”<sup>9</sup> Therefore consideration about the way the model is contracted in line with NHS regulations.

### Stages in setting up the model<sup>10</sup>

[Capitated payment system established \(and then refined\)](#) for financial stability.

#### **Alzira Model I: 1999/2003**

- Contract granted for 10 years (extendable to 15) for the management of the Specialist Medical Care of a Health Area.
- Capitation fee set: 204 €
- New Hospital de La Ribera built (private original investment of 61 M €)

#### **Alzira Model II: 2003/2018**

- Contract granted for 15 years (extendable to 20) for the management of Hospital and Primary Care for the area.
- Capitation fee set: 379€ (494€ as of 2006) + % yearly increase in the health budget (68 MM € investment during the concession).

<sup>7</sup> [Public Private partnership for hospitals - Bulletin of the World Health Organisation 84\(11\) \(2006\)](#)

<sup>8</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>9</sup> [The Search for lower cost integrated healthcare: The Alzira Model – from the Valencia Region in Spain – NHS Confederation \(2011\)](#)

<sup>10</sup> [La Ribera website](#)

## Annex C

### The DevoManc Model

The DevoManc model is a framework for the delegation and devolution of health and social care responsibilities to Greater Manchester, supported by a Memorandum of Understanding (MoU).<sup>1</sup>

#### **Where:**

- Greater Manchester (GM) is a metropolitan county in North West England, with a population of 2.8 million. It encompasses one of the largest metropolitan areas in the United Kingdom and comprises ten metropolitan boroughs: Bolton, Bury, Oldham, Rochdale, Stockport, Tameside, Trafford, Wigan, and the cities of Manchester and Salford.
- Greater Manchester was designated a City Region on 1 April 2011 when the Greater Manchester Combined Authority (GMCA) was established as the strategic county-wide authority for GM, taking on functions and responsibilities for economic development, regeneration and transport. A further devolution of powers to GM is set to take place upon the election of the inaugural Mayor of Greater Manchester scheduled for 2017.
- All local authorities within GM, all GM Clinical Commissioning Groups and NHS England are parties to the MoU.
- Greater Manchester NHS Trusts and NW Ambulance Trust (that serves GM) have also issued a letter of support.

#### **When:**

- The MoU sets out the process for collaborative working in shadow form from 1 April 2015.
- It provides a roadmap of the further detailed work that will take place leading to full devolution in April 2016.

#### **Population/ Coverage:**

- Population of 2.8million.
- Area that spans 493 square miles (1,277 km<sup>2</sup>) which roughly covers the territory of the GM Built-up Area, the second most populous urban area in the UK.

#### **Type of Model:**

- NHS England are working with GM to prepare for full devolution of relevant NHS funding to GM and for GM to be a trailblazer for the objectives set out in the Five Year Forward View.

#### **Brief Summary:**

The MoU builds on the wider Devolution Agreement which created the platform for greater freedoms and flexibilities through the invitation to GMCA and GM CCGs and Trusts to develop a strategic plan for the integration of health and social care across GM - making best use of existing budgets to transform outcomes for local communities and including specific targets for reducing pressure on A&E and avoidable hospital admissions. The keys of the model are:

- Devolved pooled budget of £6 billion, formal delegation of health and social care responsibilities to the local level.
- Greater Manchester will remain part of the NHS and social care system; it will uphold the standards set out in the national guidance and will continue to meet statutory requirements

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<sup>1</sup> [Greater Manchester Health and Social Care Devolution – Memorandum of Understanding \(2015\)](#)

## Annex C

and duties, including those of the NHS constitution and mandate and those that underpin the delivery of social care and public health services.

- New models of inclusive governance and decision-making, to enable GM commissioners, providers, patients, carers and partners to shape the future of GM together.
- The production during 2015/16 of a comprehensive GM Strategic Sustainability Plan for health and social care. This will align with the Five Year Forward View and will describe how a clinically and financially sustainable landscape of commissioning and provision could be achieved over the next five years.
- Radical approach to optimising the use of NHS and social care estates.
- Principle of subsidiarity will apply within GM.

### Scope:

The scope is comprehensive and will involve the whole health and care system:

- Acute care (including specialised services)
- Primary care (including management of GP contracts)
- Community services
- Mental health services
- Social care
- Public Health
- Health Education\*
- Research and Development\*

\*subject to discussion with the relevant bodies

### Enablers of transformation:

There will be changes to:

- Governance and regulation
- Resources and Finance
- Capital and Estate
- Workforce
- Communication and Engagement
- Information sharing and systems, including the potential for digital integration across GM.

### Phase One – the Roadmap for 2015/16

- Robust governance arrangements and a detailed delivery plan that will support devolution of the £6 billion spent on health and social care needs.
- 2015/16 will be a 'build-up' year to get all those arrangements in place. Major milestones include:

<b>April 2015</b>	Decisions about Greater Manchester will be taken with Greater Manchester.
<b>April 2015</b>	Process for establishment of shadow governance arrangements agreed and initiated
<b>October 2015</b>	Initial elements of a Business Case developed to support the CSR agreed including a specific investment fund proposal to further support primary and community care
<b>During 2015</b>	Production of an agreed GM Health and Social Care Strategic Sustainability Plan
<b>December 2015</b>	In preparation for devolution, Greater Manchester and NHS England (NHSE) will have approved the details of the devolution of funds and governance arrangements. Local authorities and CCGs will formally agree the integrated health and social care arrangements;
<b>April 2016</b>	Full devolution and/or delegation with final governance arrangements in place.

## **Annex C**

### **Governance and how decisions will be made:**

All decisions will be made on these principles:

- There is a genuine new partnership between CCGs, Councils, NHS England and other stakeholders with the shared objective of shaping the future of GM health and social care together in the interests of GM;
- NHS Services will remain as part of the NHS and be subject to the NHS Constitution and Mandate.
- CCGs and Local authorities will retain their statutory functions.
- All decisions about GM health and social care will be taken by GM as soon as possible.
- NHSE, CCG and Council accountability for funding during the first year will be as now.
- Decision making on current NHS funds will be made jointly with NHSE.
- It is proposed to implement a staged approach to the development of GM health and social care governance arrangements.

From April 2015 shadow bodies will be formed:

- A Health and Social Care Strategic Partnership Body to oversee strategic development
- A Joint Commissioning Body to agree decisions on GM-wide spend

NHS Service providers will also be invited to organise themselves in ways that will enable them to make a full contribution to the process. The aim is that from April 2016 these structures will be formalised enabling full delegation to take place. NHS England and the regulatory bodies will be fundamental parts within this new partnership.

### **Next steps:**

It is recognised that the MoU is an outline agreement with more details to follow. It is also recognised that the role of the 'roadmap' with clear milestones is crucial to the reform programme. All arrangements need to operate in shadow form initially to test integrated working across the health and social care organisations in GM and the best way to achieve devolution or delegation of NHS England budgets to GM as a place-based budget.



## Annex D

### Accountable Care Organisations (ACOs) and The Virginia Mason Model

#### Formal Accountable Care Organisations (ACOs) in the USA

- The Centre for Medicare and Medicaid Services describes an ACO as "an organisation of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."<sup>1</sup>
- Following provision for this type of organisation in the 2010 Affordable Care Act ACOs are now widely prevalent in the USA, with over half of the population estimated to reside in an area covered by one or more organisation<sup>2</sup>.
- ACOs come in a range of different structures, from single integrated delivery systems to physician led multi-speciality groups and independent practice associations<sup>3&4</sup>. They tend to consist of primary care physicians and at least one hospital.<sup>5</sup> In the Five Year Forward View PACS are referred to as similar models to the ACOs emerging in the United States.
- The traditional Medicare 'fee-for-service' payment system remains in large parts of the American healthcare system. In the ACO programme new payment and contracting mechanisms (including capitated and bundled payments) build in an incentive to be more efficient though the offer of bonuses and shared savings if providers keep costs down. Contracts build in the requirement to meet quality benchmarks and outcomes (including prevention interventions and managing those with chronic disease to avoid unnecessary hospital admissions). Providers are therefore paid more for managing clinical and cost risk by keeping their patients healthy and out of hospital settings.
- As with other examples across the Globe, some ACOs are moving beyond medical care into providing social care and using global payment mechanisms. In this format ACOs have been referred to as 'Totally Accountable Care Organisations'.<sup>6</sup>

#### The Virginia Mason Model

##### **Where:**

- Virginia Mason is a healthcare system based in in Seattle, Washington (USA).

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<sup>1</sup> [Medicare Accountable Care Organisations – Centre for Medicare and Medicaid Services](#)

<sup>2</sup> [Accountable Care Organisations in the United States: Market Demographic Factors Associated with Formation – Health Services Research \(2013\)](#)

<sup>3</sup> [Accountable Care Organisations in the United States and England – Testing, evaluation and learning what works – Kings Fund \(2014\)](#)

<sup>4</sup> [Medicare Accountable Care Organisations – Centre for Medicare and Medicaid Services](#)

<sup>5</sup> [Accountable Care Organisations in the United States and England – Testing, evaluation and learning what works – Kings Fund \(2014\)](#)

<sup>6</sup> [Broadening the ACA Story: A Totally Accountable Care Organisation - Health Affairs Organisation\(2014\)](#)

## Annex D

### **When:**

- The hospital itself has existed for some time, but in 2002 Virginia Mason embarked on a system-wide program to change the way it delivers care and in the process improve patient safety and quality.
- It did so by adapting the Toyota Production System (TPS) for application to the care they deliver, calling it the Virginia Mason Production System (VMPS).<sup>7</sup>

### **Population/ Coverage:**

- No information available on fixed coverage; patient volume in 2011 included over 800,000 physician visits, just over 16,000 in-patient hospital admissions and 18,000 surgical procedures.<sup>8</sup>

### **Type of Model:**

- A multi-speciality group ACO, Virginia Mason is a fully integrated healthcare system.
- In its own literature regarding the Federal ACO programme Virginia Mason note that they decided not to take part in the formal initiative “given the complexity and cost of participation”<sup>9</sup> and primarily because as an organisation they were already providing fully integrated care, focused on quality outcomes.

### **Summary:**

A non-profit organisation offering a system of integrated services including the following:

- A large multispecialty group practice of 460 physicians who offer both primary and specialty care.
- An acute-care hospital licensed for 336 beds.
- Research Institute at Virginia Mason.
- A network of medical centres throughout the region.
- A nursing residence and chronic care management centre for people living with AIDS and other chronic or terminal illnesses.<sup>10</sup>

### **Finance and contract:**

- The Affordable Care Act changed the system for paying for care in the USA, in an effort to reward higher quality care through value-based purchasing and holding providers accountable for health of a population. Providers are held accountable across 13 quality care measures.
- Virginia Mason described value-based purchasing as “good for patients because it will help improve the quality and safety of care they receive by providing financial incentive for hospitals to provide the best possible care. It's good for Virginia Mason because our attention to quality and extraordinary service should help us receive the maximum payment levels from Medicare, which is important for us to remain financially strong.”<sup>11</sup>

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<sup>7</sup> [Virginia Mason Website](#)

<sup>8</sup> [Virginia Mason Website](#)

<sup>9</sup> [Changing Delivery Models – Virginia Mason](#)

<sup>10</sup> [Virginia Mason: Fast Facts \(2014\)](#)

<sup>11</sup> [Value Based Purchasing – Virginia Mason](#)

## Annex D

- Virginia Mason is a non-profit health care provider governed by a board of community volunteers. The Medical Centre is a tax-exempt organisation<sup>12</sup> and savings from continuous improvement are reinvested to support patient health and wellbeing.
- Virginia Mason have indicated they would be interested in bundled payments (a single payment for complete treatment and care of overall condition/ surgery) because they consider this a fit with the Virginia Mason Production System (VMPS).<sup>13</sup>

### **Successes:**

- At the forefront of the application of continuous improvement with the result of improving patient care and driving up quality; ranked in the top 1% of hospitals for quality and efficiency, liability claims reduced<sup>14</sup> and patient waiting times cut.
- Specific examples across the system are on large and small scales i.e. developed a 'one stop care point' for cancer patients, including a laboratory and pharmacy, saving cancer patients having to walk around the building/ to different departments. In a local team example, surgery teams redesigned the equipment cart for anaesthesia tools by using a shadow board to show where the tools belonged, so that gaps immediately revealed missing supplies and instruments.<sup>15</sup>
- Developed electronic dashboards to remind clinicians of specific issues such as automatic reminders to undertake a quality review for every critical care patient.
- In July 2015 awarded contract from the Department of Health to work as the long term partner of the Trust Development Agency (TDA) to develop and implement a large scale Health Improvement Service change programme in the NHS.<sup>16</sup>

### **Enablers:**

- Adoption of the Toyota Production System: Application of a range of continuous improvement techniques to clinical and non-clinical settings, with a particular focus to improve safety and quality.
- Leadership: Chief Executive and leadership have been stable and dedicated to the change - in place and driving the process since it began, having decided that a new approach was needed for safe care and financial stability.<sup>17</sup>
- Vision and Mission: Virginia Mason have a clear mission to be the quality leader and transform health care in 'pursuit of the perfect patient experience' including a commitment "to providing a broad range of services that improve one's health and well-being and which prevent illness."<sup>18</sup>
- Embedded in the culture: Emphasis underpinning the vision and mission is that staff who do the work know what the problems are and have the best solutions.<sup>19</sup> Staff are fully trained in VMPS fundamentals and staff engagement and ownership are key features of the model.<sup>20</sup>

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<sup>12</sup> [Virginia Mason Website](#)

<sup>13</sup> [ibid](#)

<sup>14</sup> [Reducing Harm to Patients – The Health Foundation \(2014\)](#)

<sup>15</sup> [Virginia Mason Production System – Jay Arthur LinkedIn article \(2015\)](#)

<sup>16</sup> DH ITT Reference: 59867

<sup>17</sup> [Reducing Harm to Patients – The Health Foundation \(2014\)](#)

<sup>18</sup> [Virginia Mason: Fast Facts \(2014\)](#)

<sup>19</sup> [Virginia Mason Website](#)

<sup>20</sup> [Reducing Harm to Patients – The Health Foundation \(2014\)](#)

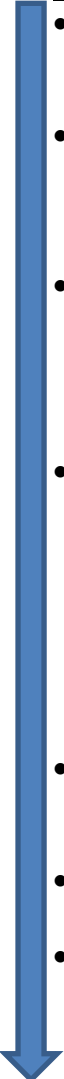
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- Electronic health record: Developed over time to support consistent, accurate records as a tool across the system.

### **Learning to be aware of for implementation of a similar model:**

- The learning is widely acknowledged and already applied in places, but attempts to implement similar tools have shown that they can be hard to embed, with need for consistent application which can be a challenge in a system where there are often policy<sup>21</sup> and organisational shifts.
- There are key differences in access to resource for training and wider workforce issues (for example, one commentator describes that doctors that couldn't fit with the new standards and methods and transparent culture left the organisation, which would not be plausible across the whole of the NHS).<sup>22</sup>

### **Steps in the model set up:**

- 
- **Late 1990's and early 2000's**: Range of financial and clinical challenges (including a preventable death) – 'turning point' triggering change.<sup>23</sup>
  - **2001/2**: The Centre's leadership team, keen to improve patient safety and quality of care, visited Japan to learn about the Toyota Production System (TPS) and returned to develop and implement tools in healthcare.
  - **VMPS embedded**: The process involves the systematic use of a management method in which the patient is put first, waste and duplication is identified and eliminated over time through exercises such as value stream mapping. Processes are then standardised. The principles are applied across the system.
  - **[on-going]** - Over 850 continuous improvement activities involving staff, patients and other stakeholders held. Virginia Mason uses several continuous improvement activities, such as Rapid Process Improvement Workshops and 'kaizen events' which focus on incremental changes, as well as '3P workshops' which look at completely redesigning a process. For safety they use 'stop-the-line' which allows staff to stop any harm activity across the whole system, with that activity not re-started until the issue is fully resolved.
  - **2003**: Introduced electronic health record which has been developed over time to support consistent, accurate records as a tool across the system.
  - **2004**: Moved to a focus on quality metric reporting.
  - **2009**: A new hospital facility was built which was designed around the patient journey and patient flow (user design focus); creating patient and provider zones and universal treatment rooms and built in safeguards such as hand washing stations.<sup>24</sup>

<sup>21</sup> [Signing up to Safety: Lessons from the Virginia Mason Model – The Health Foundation \(2014\)](#)

<sup>22</sup> [Signing up to Safety: Lessons from the Virginia Mason Model – The Health Foundation \(2014\)](#)

<sup>23</sup> [Terrible Tragedy and Powerful Legacy of Preventable Death – Virginia Mason Blog \(2014\)](#)

<sup>24</sup> [Virginia Mason's new hospital designed for care transformation – The Seattle Times \(2009\)](#)

## Annex E

### **New Zealand Case Study: Canterbury District Health Board (CDHB)**

The Canterbury District Health Board (CDHB) is an example of a developing model of integrated health and social care.

#### **Where:**

- Christchurch, New Zealand

#### **When:**

- This model developed in 2010/2011 following the earthquakes in New Zealand, building on existing work from 2007 to integrate health and social care.

#### **Population/ Coverage:**

- CDHB covers much of the health and social care for around 510,000 people.

#### **Type of Model and Brief Summary:**

- Whole system accountable care model. CDHB covers 130 GP practices, 115 Community Pharmacies, 110 dentists, 100 residential homes and 50 mental health providers and secondary care.

#### **Finance/ contracting:**

- In New Zealand Primary Health Organisations contract with District Health Boards to provide a range of primary, community health services and preventative care to a defined population.
- Canterbury moved to 'alliance' contracting (collective contract with pre-agreed gains or losses and based around overall performance)<sup>1</sup> for a range of services.
- Internally to the hospital system Canterbury moved from paying hospitals per procedure (activity) to building budgets for hospital departments from the base up.<sup>2</sup> This involved a re-focus on managing cost and resources by funding capacity rather than per procedure.<sup>3</sup>

#### **Examples of successes:**

- Despite challenges from the impact of the earthquake 2011/12 saw demand in the community better managed than elsewhere in New Zealand and a decrease in acute readmissions.<sup>4</sup>
- GPs provided with direct access to a range of diagnostic testing and range of conditions now treated in community rather than hospital setting.
- Fewer patients entering care homes, with more supported in the community and less demand for residential care.<sup>5</sup>
- As a health economy financially moved from deficit to surplus between 2007 and 2010/11.<sup>6</sup>

#### **Enablers:**

- New contracting models permitted.
- Clear mantra to improvement across whole health economy of one budget, one system, "firmly held and articulated" by leaders across the health and social care system.<sup>7</sup>

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<sup>1</sup> [The quest for integrated health and social care – A Case study in Canterbury, NZ \(2013\)](#)

<sup>2</sup> *ibid*

<sup>3</sup> *ibid*

<sup>4</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>5</sup> [The quest for integrated health and social care – A Case study in Canterbury, NZ \(2013\)](#)

<sup>6</sup> *ibid*

<sup>7</sup> [The quest for integrated health and social care – A Case study in Canterbury, NZ \(2013\)](#)

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- Ability to build on existing developed networks of organised General Practice in Canterbury, including Pegasus Health which was Christchurch's equivalent of an Independent Practice Association (IPA) and which the majority of the GPs in Canterbury belonged.<sup>8</sup> Pegasus merged with the Primary Health Organisation (PHO) in 2013.
- Can do culture "sustained through a coherent strategic vision developed at board level, but also through investment into the enablement of staff to initiate and maintain changes from the bottom up".<sup>9</sup> Achieved through a range of programmes including developing clinical leaders system wide (Xceler8), engagement and empowerment strand (Paritip8) and a programme to help staff to develop the change project (Collabor8).<sup>10</sup>
- Shared Care Record Review - which is described as an "influential feature of the transformation of cross-sector care".<sup>11</sup> – provides up to date, live electronic patient information.

### Issues/ learning/ other things to be aware of:

- The initial set-up of the model and improvement programmes have involved financial investment in staff programmes and re-designing the Health Pathways which is then maintained at a cost.<sup>12</sup>
- For 2011/12 the rate of avoidable hospital admissions per 100,000 in the population was almost identical to the UK figure.<sup>13</sup>
- The evidence is that the model appears to be working well as whole system, but further evaluation on statistical significance required as Canterbury is near the start of the transformation journey.

### History of the model – and subsequent set up:

#### 1990's: Wider Context [evolution of primary care infrastructure and incremental progress towards integration]:

- Since the early 1990's GPs and other primary care clinicians have worked collaboratively as part of Independent Practitioner Associations (IPAs). Initially, these organisations generally came together "as a defence mechanism in response to a change in government policy, which raised the threat of new contractual arrangements with GPs".<sup>14</sup>
- IPAs are autonomous networks of GP Practices - privately owned, non-statutory and a mixture of profit and non-profit status.<sup>15</sup> They have changed in form since their inception and many are now large organisations, often with a multi-disciplinary workforce and provide a range of primary care, management and support services.<sup>16</sup>

**2002:** Primary Health Organisations (PHOs) were introduced in New Zealand as part of the Labour Government's Primary Care Strategy. Aim to increase funding to primary care and ultimately address health inequalities. PHOs contract with District health boards to provide primary care and preventive services for a defined population<sup>17</sup> including the

<sup>8</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>9</sup> ibid

<sup>10</sup> ibid

<sup>11</sup> ibid

<sup>12</sup> [The quest for integrated health and social care – A Case study in Canterbury, NZ \(2013\)](#)

<sup>13</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>14</sup> [Primary Care for the 21<sup>st</sup> Century: Learning from New Zealand's independent practitioner associations – Nuffield Trust \(2012\)](#)

<sup>15</sup> ibid

<sup>16</sup> ibid

<sup>17</sup> [Primary Care for the 21<sup>st</sup> Century: Learning from New Zealand's independent practitioner associations – Nuffield Trust \(2012\)](#)

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responsibility for providing out of hours care.<sup>18</sup> Some IPAs re-established themselves as PHOs. Some provided management/ support functions to PHOs and others became network organisations existing alongside PHOs.<sup>19</sup>

**2007:** Main hospital in Christchurch regularly gridlocked in A&E, long waits, bed shortages.<sup>20</sup> Drive in the system for change and integration of health and social care.

Changes in healthcare reform empowered district health boards to decide on their own contracting models for funding hospitals.

**2010/2011:** Catastrophic earthquakes in New Zealand, with huge impact across Canterbury. Many health and care settings destroyed or very damaged and 11 clinicians were killed.

**2011 – Current:** City regeneration programme

- Range of improvement programmes and system re-design to ensure people treated in the right place at the right time. For example, Health Pathways programme (ensuring consistent services delivered in the most convenient settings) e.g. in first 11 month of new ambulance pathway for patients with Chronic Obstructive Pulmonary Disease which introduced new ways for paramedics to assess and arrange most appropriate care led to 556 out of 1714 patients being treated in the community and not admitted to A&E.<sup>21</sup>
- Other areas of focus include an Acute Demand Management Service delivered by GPs and Community health staff to support those urgently unwell and a Community Rehabilitation Enablement Support Team who support those medically stable but in need of other support at home. There is a community based falls programme and development is underway for fully integrated model of care for adult and mental health and care services.

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<sup>18</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#)

<sup>19</sup> [Primary Care for the 21<sup>st</sup> Century: Learning from New Zealand's independent practitioner associations – Nuffield Trust \(2012\)](#)

<sup>20</sup> [The quest for integrated health and social care – A Case study in Canterbury, NZ \(2013\)](#)

<sup>21</sup> [Evidence Based Review: Accountable Care Organisations – East Midlands Science Network \(2014\)](#) from information provided by the Canterbury District Health Board.

## Annex F

### Capitated Payments: Overview

As highlighted in the report, capitated payment is considered one of the key enablers in accountable models of care and is used in several of the examples of best practice. This Annex provides additional detail about capitated payments and the choices and steps that would need to be considered if this mechanism was to be implemented as part of a new model of accountable care for East Sussex.

#### **What is Capitated payment?**

In contrast to payment by activity, capitated payments “allows commissioners to reimburse providers for making available specified services and delivering specified outcomes for a defined target population, drawing on services that cross different organisational boundaries to meet individual patient needs”.<sup>1</sup>

The payment is usually weighted or risk-adjusted to take into account the fact that some groups may require more expensive or more frequent services than some others<sup>2</sup> and is therefore sometimes referred to as “risk contracting”.<sup>3</sup> As in the Alzira model, if the provider(s) meet the responsibility for delivering whole person care for each member of the target population, they will generate a financial gain for the East Sussex Health Economy.

Capitated payments are a single payment covering all/ most of the care needs of the population cohort, rather than a set of payments each covering part of the care pathway (one for acute, one for primary care, one for social care etc.). This is because only the whole cohort/ population focus is likely to incentivise the coordination of care and realise a shift to early intervention. Separate payments also risk building in an incentive to shift care to another setting, as seen initial issues in the Alzira model which were resolved by the inclusion of primary care in the revised contract.

#### **Who is it paid to?**

The payments are generally made to a single provider (the capitated budget holder) or can be made to a group of providers who then make the arrangements with others to deliver the full scope of services specified by the Commissioners, including “provider to provider payment mechanisms” for the budget holder to pay others.<sup>4</sup>

#### **Who and what is it paid for?**

Capitated payments can be made for a whole population such as in the Alzira model which is setup for a defined geographical, whole population basis. Alternatively, they can be designed to cover specific cohorts of the population, as with the North West London CCG Integrated Care Pilot, in which cohorts were selected based on a combination of age and health and social care needs. For example we may wish to target groups such as those with multiple long term conditions. NHS England and Monitor describe the advantage of the latter as “capitation for a target population provides an opportunity for organisations to build the capabilities of the integrated care model, develop patient-level linked datasets, fix financial

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<sup>1</sup> [Capitation: a potential new payment model to enable integrated Care - NHS England and Monitor – \(November 2014\)](#)

<sup>2</sup> [The NHS Payment System: Evolving Policy and Emerging Evidence – Nuffield Trust \(2014\)](#)

<sup>3</sup> [GP Budget Holding: Lessons from Across the Pond and from the NHS – University of Birmingham Health Service Management Centre \(2010\)](#)

<sup>4</sup> [Capitation: a potential new payment model to enable integrated Care - NHS England and Monitor – \(November 2014\)](#)



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incentives and adjust sharing factors each year so that providers can take on more financial risk before this approach is rolled out to a larger population".<sup>5</sup>

### Targeting payments on outcomes:

To ensure high quality care the payment mechanism can be focused on both quality and outcomes – otherwise there is a risk of quality of care diminishing (e.g. treatment in the cheapest rather than most effective settings). Commissioners can decide that a proportion of the payment itself is dependent on the achievement of outcomes/ specific quality targets by the accountable provider(s).<sup>6</sup>

### What are the advantages of this mechanism in an accountable care model?

- An element of predictable cost for commissioners. In the Alzira model this cost was also lower than that achieved elsewhere in the Valencia region.
- As providers take on a greater financial risk there is a built in incentive to shift investment to preventative care and in the lowest cost setting and make system efficiency savings, in addition to the incentive for joined up care.
- Part of the capitated payment mechanism is the upfront payment which would also make an element of provider's income more predictable and stable. In turn this could make it more feasible for providers to be able to plan, implement service changes for the better<sup>7</sup>.
- Allows opportunity for investment in infrastructure and technology to improve the service for patients.
- Allows opportunity for providers to decide the best intervention for the patient as a whole.
- Allows opportunity to make further efficiency savings across the whole system with an incentive to do so to ensure maximum surplus for reinvestment into improvements for patients.

### What are the risks that need to be mitigated with capitated payments?

Safeguards need to be in place to mitigate potential risks associated with capitated payments. There are useful lessons from the managed care backlash in Health Maintenance Organisations in the USA in the 1990's which have been addressed in the newly emerging Accountable Care Organisation models in America. These organisations widely used capitated payments but generally without the same emphasis on quality/outcomes and without the same element of patient choice. This led to many to see their primary care physician to be a 'gatekeeper' preventing access to services.<sup>8</sup> NHS England and Monitor highlight the following key risks, summarised below:

- Access to care is restricted with the least complex patients 'cherry picked', or a reduction on the quality of care provided.
- The capitated budget holder find its financial sustainability and stability is at risk, possibly leading to financial distress.
- Care is shifted to settings not covered by the capitated payment (if the payment does not cover all types of care), running the risk of the commissioner paying twice for the same service.

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<sup>5</sup> [Capitation: a potential new payment model to enable integrated Care - NHS England and Monitor – \(November 2014\)](#)

<sup>6</sup> [ibid](#)

<sup>7</sup> [ibid](#)

<sup>8</sup> [GP Budget Holding: Lessons from Across the Pond and from the NHS – University of Birmingham Health Service Management Centre \(2010\)](#)

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- Not enough is invested in prevention and improving productivity in the long run to yield the expected health economy benefits (a risk which increases if contract lengths are too short to make investments worthwhile for providers, e.g. less than 3-5 years).
- Restricting patient choice (if the contract does not include a requirement for the patient to choose to go elsewhere at a cost to the capitated budget holder).

### What are the key steps/ decisions if we were to set up a capitated payment in East Sussex?<sup>9</sup>

#### Identify the population

- **Decide who is going to be included in the capitated payment.**
- For example, whole population over a geographical area (all East Sussex population of 540,000, or based on localities etc) or a cohort of people across East Sussex who would particularly benefit from more co-ordinated care (and establish numbers of this group).
- Is the population cohort relatively homogenous in terms of care and the related costs?
- Is the population size large enough to mitigate the financial risks from random variations?
- How are they identified (GP lists?)

#### Scope of the services

- **Decide what services are going to be included in the capitated payment.**
- all health and social care services? Health and free social care services? Any exceptions (e.g. highly specialised services such as organ transplant or secure mental health?)

#### Determine the unit price

- **Decide on the unit price per person per year for the capitated payment.**
- What method will be used for determining the price e.g. historical provider costs or combined commissioner spend for the selected cohort.
- Adjustments for local assumptions?

<sup>9</sup> This chart is adapted from summary headings and design lists in [Capitation: a potential new payment model to enable integrated Care - NHS England and Monitor – \(November 2014\)](#) and [Accountable Care: Focusing Accountability on the Outcomes That Matter - WISH \(2013\)](#)

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### Agree financial risk mitigation mechanisms

- **Agree the mechanisms that could be put in place to ensure that the provider, as capitated budget holder, can manage the financial risk.**
- e.g. excluding from the payment arrangements infrequent, high cost services or patients whilst maintaining the patient care delivery model.
- Define financial gain/loss sharing arrangements
- multilateral risk sharing arrangements would be put in place so that budgets could be managed effectively.
- Length of contract?

### Agree provider - provider payment mechanisms

- **Agree and design the payment mechanisms for provider to provider (sub-contractor) payments that be put in place between the capitated budget holder and others.**

### Identify and set performance measures and define the quality and outcome incentives

- **Identify and define performance measures and link to the final payment made to the provide/ provider(s)**
- Focus on outcomes measures and quality measures to ensure the focus on improved outcome for the entire patient cohort.
- Decide on what the quality and outcome incentives are.

### Other considerations

- **Testing** needs to be agreed: how does the model get tested e.g. in shadow form?
- Implementation needs to be in line with rules Governing Capitated payments and on locally determined prices (procurement expertise).

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- **Governance arrangements** need to be agreed including that providers will need to agree a process for resolving conflicts that arise.<sup>10</sup> This may require legal agreements binding providers together and outlining roles.
- **Quality of data and reporting** is key for **metrics and learning**. For example both to monitor activity levels/ quality/ outcomes and also to inform the design of developing programmes. The data will also be essential to gain insight about patients to identify where best to target interventions (both in the stage of identifying cohorts of patients and then within the capitated payment to target resource and interventions).
- **Population Size:** From the examples considered and the literature around accountable models of care, definitive data on how large groups need to be does not exist. Some experts estimate that organisations should have a minimum of 100,000 patients to take on global capitation with others believing lower numbers could be sufficient.<sup>11</sup> A 2014 analysis of 172 ACOs in the USA noted that ACOs generally serve a defined population of between 5,000 and 50,000 people<sup>12</sup>, but little information is given to the effectiveness or impact of population cohort sizes on the models beyond avoiding making the group too small to allow variations in care cost to be averaged out.

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<sup>10</sup> [Implementing the NHS Five Year Forward View: Aligning policies with the plan – The Kings Fund \(2015\)](#)

<sup>11</sup> [GP Budget Holding: Lessons from Across the Pond and from the NHS – University of Birmingham Health Service Management Centre \(2010\)](#)

<sup>12</sup> [Accountable Care Organisations in the United States and England – Testing, evaluation and learning what works – Kings Fund \(2014\)](#)

## Annex G - Summary of Contracting Models<sup>1</sup>

Definition and purpose	Characteristics	Benefits/success factors	Use of Incentives	Issues
<b>1) Accountable Care Organisations</b>				
<p>Groups of primary and secondary care physicians, and other healthcare providers working together to avoid duplication of services and integrate care. Goals are to align care, reduce costs and increase quality through primary care, chronic disease prevention and population health.</p>	<ul style="list-style-type: none"> <li>• Care coordination amongst providers to streamline services.</li> <li>• Shift away from episodic fee-for-service system to capitated and performance payment system</li> <li>• Public reporting of the quality of care</li> <li>• Efficiencies are driven through patient health outcomes</li> <li>• Outcomes-based - can consider non-clinical interventions to address social norms at an individual and population level that affect health</li> <li>• Health information exchange is seen as huge benefit to assure that all providers across a community have access to the same patient information for care coordination, unnecessary testing and improved chronic disease management</li> </ul>	<ul style="list-style-type: none"> <li>• Largely embedded in US systems and no evidence of effectiveness to date.</li> <li>• Rate of increase in spending has slowed compared to control groups</li> <li>• Savings through lower prices from shifting procedures, imaging and tests to facilities with lower fees and reduced used amongst some groups.</li> <li>• Improved quality of care compared to control organisations with chronic care management, adult preventative care and paediatric care within the contracting groups improving more.</li> </ul>	<ul style="list-style-type: none"> <li>• Shared savings with 'payer' if quality metrics are met and healthcare spending is reduced to levels below projected costs</li> <li>• Potential to align incentives to improve system quality and reduce healthcare costs across populations which can be achieved through needing to look at maintaining the health of large patient populations and looking at all factors that affect health including social determinants.</li> <li>• Query about whether ACOs can incentivise changes in physician behaviour</li> </ul>	<ul style="list-style-type: none"> <li>• Addresses both payment and delivery reform in the healthcare system</li> <li>• In the US model start-up costs are the most challenging aspect, and may outweigh potential savings.</li> <li>• Care coordination still dependent on collaboration, communication and teamwork</li> </ul>

<sup>1</sup> Taken from: Contracting for Integrated health and social care: a critical review of four models, Journal of Integrated Care (2015)

<b>2) Alliance Contracting Model</b>				
<p>One contract between the commissioner and an alliance of parties who deliver the service or programme with risk share across all parties, collective ownership of opportunities and responsibilities associated with delivering the whole service or programme</p>	<ul style="list-style-type: none"> <li>• Relational aspects relating to trust, loyalty, and commitment for the long term.</li> <li>• Agreement between parties to work cooperatively to achieve agreed outcomes and on the basis of sharing risks and rewards.</li> <li>• Longer duration and involve more intricate administrative structures and dispute resolution techniques and specify the exchange of much more organisation-specific information, technical knowledge and capabilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Effective at transferring knowledge and spreading risks.</li> <li>• Benefits include strong incentives to collaborate, limited dominance of a single organisation, strengthened relationships between commissioners and providers and retaining the active involvement of commissioners.</li> <li>• Largely process factors and 'lessons learnt' rather than evidence base of effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>• Payment mechanisms can be structured to spread risk that link each party to the overall success of the service</li> </ul>	<ul style="list-style-type: none"> <li>• Heavy administrative burden which can become easily strained.</li> <li>• High failure rate of organisations in alliances due to competition between partners and power seeking through knowledge-sharing as well as inability to guard against opportunistic behaviour</li> <li>• Multiple alliance contracts may result in confusion about purpose</li> </ul>
<b>3) Lead Provider/Prime Contractor Model</b>				
<p>Delivers service integration and transformation through one accountable lead provider having responsibility through a contract for subcontracting to other</p>	<ul style="list-style-type: none"> <li>• Outcome-based contract let to a single accountable lead provider for the whole integrated programme of care, each containing a number of related pathways.</li> <li>• Clinical and financial incentives will be aligned through the lead provider's management of the programme using different contract mechanisms to take on programme risk and accountability.</li> <li>• Different forms of contract pricing</li> </ul>	<ul style="list-style-type: none"> <li>• Applied in Australia models tend to be locally based partnership-type approaches for delivering services to a specific client-group</li> <li>• Outcomes-based commissioning is strongly linked with this model</li> <li>• Significant stakeholder</li> </ul>	<ul style="list-style-type: none"> <li>• Different aspects of care will be incentivised by the lead provider to work together into a coherent patient pathway, making it clear that each aspect of care will be incomplete unless integration with each other takes place. This provides the lead</li> </ul>	<ul style="list-style-type: none"> <li>• Might be difficult and a challenge to understand and decide who will carry out the integrator role given the current NHS institutional framework of large organisations providing secondary and tertiary care and very small ones</li> </ul>

<p>providers for the various aspects of care bringing together episodic providers of care into a single care pathway</p>	<p>and much less pathway micro-management.</p> <ul style="list-style-type: none"> <li>• Budget based on total programme of care not reproduction of episodes e.g. based on Year of Care costs for long-term condition patients</li> <li>• The lead provider will support primary care in its pathway whilst at the same time managing unwarranted variation in primary care referrals and the gateway into hospital</li> <li>• Rationalises of the number of contracts with providers</li> <li>• Accountable prime provider, active integrator and non –lead provider all appear to be variations on this; no clear demarcation between named models and how they are being used in practice; better to focus on how the principles or ambitions that underpin the desired transformation can in general be built into the contract.</li> </ul>	<p>interest in the UK owing to the model's use in a variety of ways; community-based self-care for persistent pain, GP-led diabetes care, integrated pathway hubs for MSK and cancer and end-of life services.</p> <ul style="list-style-type: none"> <li>• Strong belief that this is a new sustainable approach to commissioning care and to transform the quality and productivity of care pathways as well as shifting clinical accountability onto integrator and providers</li> </ul>	<p>provider (with its subcontractors) the ability to construct the overall pathway of care with incentives that provide the commissioners with the outcomes they want.</p>	<p>providing primary care. Large federations of GPs might be able to take on the risk</p> <ul style="list-style-type: none"> <li>• Challenges for prime providers in managing risks and liabilities</li> <li>• Contract needs to be framed at the right level of need, and ensure the in the knowledge transfer a commonality of language and meaning from each of the contractors on the pathway</li> <li>• Contract is for healthcare outcomes outside the control of the hospital and the acute provider will be part of a very different non-hospital based business model</li> </ul>
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**4) Outcome-based Contracting and Commissioning and Contracting Outcomes Based Incentivised Contracts (COBIC)**

<p>Shifts the focus from activities to results, form how a programme operates to the good it accomplishes</p>	<p>Performance-based' contracting: outcome criteria, expectations and measures are defined through providing incentives and monitoring performance e.g. a measure could be the extent to which a health condition or behaviours has improved and the evidence that the</p>	<ul style="list-style-type: none"> <li>• Emphasis on allowing time to define outcomes to be tested through stakeholder involvement, and linking them to business plan, organisational goals</li> </ul>	<p>Milton Keynes substance misuse model combined capitation and rewards for improved outcomes. Money for services was reduced but providers were allowed to keep the money generated by not</p>	<ul style="list-style-type: none"> <li>• Difficulties in specifying and measuring outcomes, alongside interpretation/attributi on of results</li> <li>• COBICS proponents advocate the</li> </ul>
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	<p>implementation/intervention processes have achieved this outcome. Underpins ACOs in the US and Values-based Healthcare</p>	<p>and inter-agency strategies</p> <ul style="list-style-type: none"> <li>• No evidence on effectiveness</li> </ul>	<p>delivering unnecessary care – the long-term effectiveness of this is yet to be established</p>	<p>Accountable Lead Provider Model as the best fit to operationalise the approach, as different providers need to respond to single tenders in partnership and to work outside of their particular part of the pathway</p> <ul style="list-style-type: none"> <li>• Use of competitive dialogue may help commissioners to develop outcomes that can be delivered and measured.</li> </ul>
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